Budget Agreement?
Andrew J. Rettenmaier and Thomas R. Saving

Last month, the Supreme Court ruled that the Affordable Care Act’s penalty for not complying with the individual mandate was constitutional as a tax. However, the Act’s requirement that states expand Medicaid or lose their existing federal funding was deemed unconstitutional. In addition to the contested aspects of the Act, other provisions will affect federally financed health care for years to come. Medicare spending in particular is slated for significant reductions relative to previous projections. Interestingly, while few believe the Medicare spending reductions as specified in the Act will be realized, both parties now appear to embrace the dramatically lower Medicare forecasts as annual spending targets.

The reductions in spending result from two new provisions aimed at constraining Medicare’s growth. The one that receives the most attention is the creation of the Independent Payment Advisory Board, or IPAB. The Board has broad latitude to recommend payment rate adjustments, and its recommendations are automatically implemented unless overruled by Congress. Under the Panel’s recommendations, Medicare spending must not grow more rapidly than nominal per capita GDP growth plus one percentage point. The proponents of the Affordable Care Act, or ACA, see the IPAB as a powerful tool in constraining Medicare spending growth because it takes an act of Congress to undo its recommendations. However, another provision has received less attention, but it actually constrains Medicare spending more than IPAB will. This provision imposes a productivity adjustment that reduces payment rate updates by the growth in economy-wide productivity. This stipulation basically requires that Medicare providers keep pace with economy-wide productivity gains or their costs will outstrip their reimbursements. However, achieving such gains is unlikely in the labor-intensive health care sector.

The productivity adjustment affects payments to hospitals under Part A of the program and to the non-physician portion of Part B. Medicare already pays providers less than do private insurers, and the relative payment rate will continue to decline in future years. Estimates from the Office of the Actuary at the Centers for Budget Agreement?
Andrew J. Rettenmaier and Thomas R. Saving

Last month, the Supreme Court ruled that the Affordable Care Act’s penalty for not complying with the individual mandate was constitutional as a tax. However, the Act’s requirement that states expand Medicaid or lose their existing federal funding was deemed unconstitutional. In addition to the contested aspects of the Act, other provisions will affect federally financed health care for years to come. Medicare spending in particular is slated for significant reductions relative to previous projections. Interestingly, while few believe the Medicare spending reductions as specified in the Act will be realized, both parties now appear to embrace the dramatically lower Medicare forecasts as annual spending targets.

The reductions in spending result from two new provisions aimed at constraining Medicare’s growth. The one that receives the most attention is the creation of the Independent Payment Advisory Board, or IPAB. The Board has broad latitude to recommend payment rate adjustments, and its recommendations are automatically implemented unless overruled by Congress. Under the Panel’s recommendations, Medicare spending must not grow more rapidly than nominal per capita GDP growth plus one percentage point. The proponents of the Affordable Care Act, or ACA, see the IPAB as a powerful tool in constraining Medicare spending growth because it takes an act of Congress to undo its recommendations. However, another provision has received less attention, but it actually constrains Medicare spending more than IPAB will. This provision imposes a productivity adjustment that reduces payment rate updates by the growth in economy-wide productivity. This stipulation basically requires that Medicare providers keep pace with economy-wide productivity gains or their costs will outstrip their reimbursements. However, achieving such gains is unlikely in the labor-intensive health care sector.

The productivity adjustment affects payments to hospitals under Part A of the program and to the non-physician portion of Part B. Medicare already pays providers less than do private insurers, and the relative payment rate will continue to decline in future years. Estimates from the Office of the Actuary at the Centers for Budget Agreement?
Andrew J. Rettenmaier and Thomas R. Saving

Last month, the Supreme Court ruled that the Affordable Care Act’s penalty for not complying with the individual mandate was constitutional as a tax. However, the Act’s requirement that states expand Medicaid or lose their existing federal funding was deemed unconstitutional. In addition to the contested aspects of the Act, other provisions will affect federally financed health care for years to come. Medicare spending in particular is slated for significant reductions relative to previous projections. Interestingly, while few believe the Medicare spending reductions as specified in the Act will be realized, both parties now appear to embrace the dramatically lower Medicare forecasts as annual spending targets.

The reductions in spending result from two new provisions aimed at constraining Medicare’s growth. The one that receives the most attention is the creation of the Independent Payment Advisory Board, or IPAB. The Board has broad latitude to recommend payment rate adjustments, and its recommendations are automatically implemented unless overruled by Congress. Under the Panel’s recommendations, Medicare spending must not grow more rapidly than nominal per capita GDP growth plus one percentage point. The proponents of the Affordable Care Act, or ACA, see the IPAB as a powerful tool in constraining Medicare spending growth because it takes an act of Congress to undo its recommendations. However, another provision has received less attention, but it actually constrains Medicare spending more than IPAB will. This provision imposes a productivity adjustment that reduces payment rate updates by the growth in economy-wide productivity. This stipulation basically requires that Medicare providers keep pace with economy-wide productivity gains or their costs will outstrip their reimbursements. However, achieving such gains is unlikely in the labor-intensive health care sector.

The productivity adjustment affects payments to hospitals under Part A of the program and to the non-physician portion of Part B. Medicare already pays providers less than do private insurers, and the relative payment rate will continue to decline in future years. Estimates from the Office of the Actuary at the Centers for Budget Agreement?
Andrew J. Rettenmaier and Thomas R. Saving

Last month, the Supreme Court ruled that the Affordable Care Act’s penalty for not complying with the individual mandate was constitutional as a tax. However, the Act’s requirement that states expand Medicaid or lose their existing federal funding was deemed unconstitutional. In addition to the contested aspects of the Act, other provisions will affect federally financed health care for years to come. Medicare spending in particular is slated for significant reductions relative to previous projections. Interestingly, while few believe the Medicare spending reductions as specified in the Act will be realized, both parties now appear to embrace the dramatically lower Medicare forecasts as annual spending targets.

The reductions in spending result from two new provisions aimed at constraining Medicare’s growth. The one that receives the most attention is the creation of the Independent Payment Advisory Board, or IPAB. The Board has broad latitude to recommend payment rate adjustments, and its recommendations are automatically implemented unless overruled by Congress. Under the Panel’s recommendations, Medicare spending must not grow more rapidly than nominal per capita GDP growth plus one percentage point. The proponents of the Affordable Care Act, or ACA, see the IPAB as a powerful tool in constraining Medicare spending growth because it takes an act of Congress to undo its recommendations. However, another provision has received less attention, but it actually constrains Medicare spending more than IPAB will. This provision imposes a productivity adjustment that reduces payment rate updates by the growth in economy-wide productivity. This stipulation basically requires that Medicare providers keep pace with economy-wide productivity gains or their costs will outstrip their reimbursements. However, achieving such gains is unlikely in the labor-intensive health care sector.

The productivity adjustment affects payments to hospitals under Part A of the program and to the non-physician portion of Part B. Medicare already pays providers less than do private insurers, and the relative payment rate will continue to decline in future years. Estimates from the Office of the Actuary at the Centers for Budget Agreement?
Andrew J. Rettenmaier and Thomas R. Saving

Last month, the Supreme Court ruled that the Affordable Care Act’s penalty for not complying with the individual mandate was constitutional as a tax. However, the Act’s requirement that states expand Medicaid or lose their existing federal funding was deemed unconstitutional. In addition to the contested aspects of the Act, other provisions will affect federally financed health care for years to come. Medicare spending in particular is slated for significant reductions relative to previous projections. Interestingly, while few believe the Medicare spending reductions as specified in the Act will be realized, both parties now appear to embrace the dramatically lower Medicare forecasts as annual spending targets.

The reductions in spending result from two new provisions aimed at constraining Medicare’s growth. The one that receives the most attention is the creation of the Independent Payment Advisory Board, or IPAB. The Board has broad latitude to recommend payment rate adjustments, and its recommendations are automatically implemented unless overruled by Congress. Under the Panel’s recommendations, Medicare spending must not grow more rapidly than nominal per capita GDP growth plus one percentage point. The proponents of the Affordable Care Act, or ACA, see the IPAB as a powerful tool in constraining Medicare spending growth because it takes an act of Congress to undo its recommendations. However, another provision has received less attention, but it actually constrains Medicare spending more than IPAB will. This provision imposes a productivity adjustment that reduces payment rate updates by the growth in economy-wide productivity. This stipulation basically requires that Medicare providers keep pace with economy-wide productivity gains or their costs will outstrip their reimbursements. However, achieving such gains is unlikely in the labor-intensive health care sector.

The productivity adjustment affects payments to hospitals under Part A of the program and to the non-physician portion of Part B. Medicare already pays providers less than do private insurers, and the relative payment rate will continue to decline in future years. Estimates from the Office of the Actuary at the Centers for Budget Agreement?
Andrew J. Rettenmaier and Thomas R. Saving

Last month, the Supreme Court ruled that the Affordable Care Act’s penalty for not complying with the individual mandate was constitutional as a tax. However, the Act’s requirement that states expand Medicaid or lose their existing federal funding was deemed unconstitutional. In addition to the contested aspects of the Act, other provisions will affect federally financed health care for years to come. Medicare spending in particular is slated for significant reductions relative to previous projections. Interestingly, while few believe the Medicare spending reductions as specified in the Act will be realized, both parties now appear to embrace the dramatically lower Medicare forecasts as annual spending targets.

The reductions in spending result from two new provisions aimed at constraining Medicare’s growth. The one that receives the most attention is the creation of the Independent Payment Advisory Board, or IPAB. The Board has broad latitude to recommend payment rate adjustments, and its recommendations are automatically implemented unless overruled by Congress. Under the Panel’s recommendations, Medicare spending must not grow more rapidly than nominal per capita GDP growth plus one percentage point. The proponents of the Affordable Care Act, or ACA, see the IPAB as a powerful tool in constraining Medicare spending growth because it takes an act of Congress to undo its recommendations. However, another provision has received less attention, but it actually constrains Medicare spending more than IPAB will. This provision imposes a productivity adjustment that reduces payment rate updates by the growth in economy-wide productivity. This stipulation basically requires that Medicare providers keep pace with economy-wide productivity gains or their costs will outstrip their reimbursements. However, achieving such gains is unlikely in the labor-intensive health care sector.

The productivity adjustment affects payments to hospitals under Part A of the program and to the non-physician portion of Part B. Medicare already pays providers less than do private insurers, and the relative payment rate will continue to decline in future years. Estimates from the Office of the Actuary at the Centers for Budget Agreement?
Andrew J. Rettenmaier and Thomas R. Saving

Last month, the Supreme Court ruled that the Affordable Care Act’s penalty for not complying with the individual mandate was constitutional as a tax. However, the Act’s requirement that states expand Medicaid or lose their existing federal funding was deemed unconstitutional. In addition to the contested aspects of the Act, other provisions will affect federally financed health care for years to come. Medicare spending in particular is slated for significant reductions relative to previous projections. Interestingly, while few believe the Medicare spending reductions as specified in the Act will be realized, both parties now appear to embrace the dramatically lower Medicare forecasts as annual spending targets.

The reductions in spending result from two new provisions aimed at constraining Medicare’s growth. The one that receives the most attention is the creation of the Independent Payment Advisory Board, or IPAB. The Board has broad latitude to recommend payment rate adjustments, and its recommendations are automatically implemented unless overruled by Congress. Under the Panel’s recommendations, Medicare spending must not grow more rapidly than nominal per capita GDP growth plus one percentage point. The proponents of the Affordable Care Act, or ACA, see the IPAB as a powerful tool in constraining Medicare spending growth because it takes an act of Congress to undo its recommendations. However, another provision has received less attention, but it actually constrains Medicare spending more than IPAB will. This provision imposes a productivity adjustment that reduces payment rate updates by the growth in economy-wide productivity. This stipulation basically requires that Medicare providers keep pace with economy-wide productivity gains or their costs will outstrip their reimbursements. However, achieving such gains is unlikely in the labor-intensive health care sector.

The productivity adjustment affects payments to hospitals under Part A of the program and to the non-physician portion of Part B. Medicare already pays providers less than do private insurers, and the relative payment rate will continue to decline in future years. Estimates from the Office of the Actuary at the Centers for
The Trustees Reports. They suggest that readers view the current law estimates as “very favorable financial outcomes that would be experienced if the physician fee reductions were implemented and if the productivity adjustments and IPAB measures in the Affordable Care Act could be sustained in the long range. (2012 Medicare Trustees Report, p.5)”

Figure 1 depicts total Medicare spending as a percent of total Social Security spending. Both of these programs serve essentially the same group of beneficiaries – primarily retirees, though both programs also provide benefits for the disabled. Tracking this percentage over time illustrates Medicare’s relative growth. Social Security provides inflation-adjusted benefits that for the average worker replace between 40 and 50 percent of wage-indexed earnings and a much higher percentage of price-indexed earnings. As the figure shows, from 1970 – five years after Medicare’s inception – until 2011, Medicare benefits grew from about 20 to 75 percent of Social Security benefits. Under the pre-ACA forecasts from the 2009 Trustees Reports, Medicare spending is expected to surpass Social Security spending by 2028. But with the 2012 Trustees Reports, Medicare spending is not expected to surpass Social Security spending until mid-century.

Even with the substantially lower Medicare spending that incorporates the ACA provisions, it is important to note that Medicare spending continues to grow relative to Social Security spending; it is “cut” when compared to previous estimates.

Though the productivity gains are unlikely to occur over the long-run and the SGR formula has continually been overridden, both must be included in the current law forecasts. The Medicare Trustees and the Congressional Budget Office have made several sets of long range forecasts since the passage of the ACA, all of which incorporate the productivity adjustment and include the SGR mechanism. Over the first 20 years of the baseline forecasts that adhere to current law, the Trustees’ and the CBO’s estimates are quite similar. After the first two decades, the CBO’s baseline forecast assumes that spending per beneficiary will resume its pre-ACA growth rate. The Trustees’ baseline forecast assumes that the productivity adjustments and the SGR formula apply indefinitely. However, they note that, “Medicare’s actual future costs are highly uncertain and are likely to exceed those shown by the current-law projections in this report.” (2012 Medicare Trustees Report, p. 5)

The Trustees and the CBO also produce alternative forecasts that relax some of the current law provisions deemed unlikely to hold in the long-run. These estimates are significantly higher than the current law forecasts, and just as the CBO’s baseline forecasts are higher than the Trustees, so are its alternative forecasts. All of this indicates the immense uncertainty involved in forecasting Medicare spending and how the program’s spending is subject to the behavior of the consumers it empowers and the suppliers it pays.

Medicare spending per enrollee has grown at rates similar to per capita health care spending in the private market as consumers and providers have responded to the program’s historical payment structures. Continued taxpayer financing under the historical regime will result in ever-expanding spending and continually rising tax rates. But
because Medicare’s payment structures are determined in the political arena, changes like the SGR mechanism and the ACA productivity adjustments are offered as solutions, even though they may not work. Remarkably, both parties appear to accept the spending levels implied by the ACA despite the fact that the Trustees view the forecasts as optimistic.

Figure 2 illustrates the ratio of Medicare spending as a percent of GDP (net of premiums) as specified by the House Budget Committee in March 2012 to the same figure from the President’s 2013 Budget. The President’s Budget estimates basically follow the estimates in the 2011 Trustees Report. As the figure shows, the spending constraints are essentially the same. Thus, there appears to be agreement, at least on the desired size of the taxpayer financing of the Medicare program. The disagreement comes in how to realize the lower spending levels.

The ACA attempts to squeeze all of the savings from providers and will result in numerous detrimental outcomes for seniors, including severe access to care problems and diminished quality. In contrast, a premium support model could set the growth rate for the risk adjusted amounts and allow seniors to purchase more insurance. This will lower taxpayers’ spending on seniors’ health care but will probably require significant means-testing with the premium support amount declining as income rises. This reform could have long lasting durability if coupled with other changes in the health care market.

If either type of Medicare reform is successful, tax-financed spending on behalf of seniors will decline relative to the pre-reform path. Given that the pre-reform path is considered unsustainable, an alternative path must be found, preferably one that gives seniors more flexibility, while ensuring access for the most vulnerable.

Many have criticized the US health care market because it makes up a larger share of the national economy than in other developed countries. Further, because its share of the economy continues to expand and is heavily financed through the tax system, health care reform must encompass more than just Medicare reform.

While the justices’ ruling has ensured the ACA’s survival for now, it is clear that more reforms are yet to come. Lasting reforms can reduce the distortions prevalent in each part of the health care market. The reforms can begin with reconsidering the preferential tax treatment of employer-provided health insurance. The employer-based tax exclusion is a remnant of another era, and it is responsible for most of the problems we now face. Preferential tax treatment may be justified for major medical insurance or for a limited dollar amount, but tying it to employment is both unnecessary and detrimental. Limiting the tax preference health insurance enjoys will reduce (tax) spending on the young and thereby reduce what the public expects in terms of the government provided health care for seniors and the indigent. Health insurance will then return to being protection against the unexpected, and the market will function like a more conventional market in which prices inform both patients and providers.